Alaska Health Care Commission

Meeting Discussion Guide

June 19-20, 2014

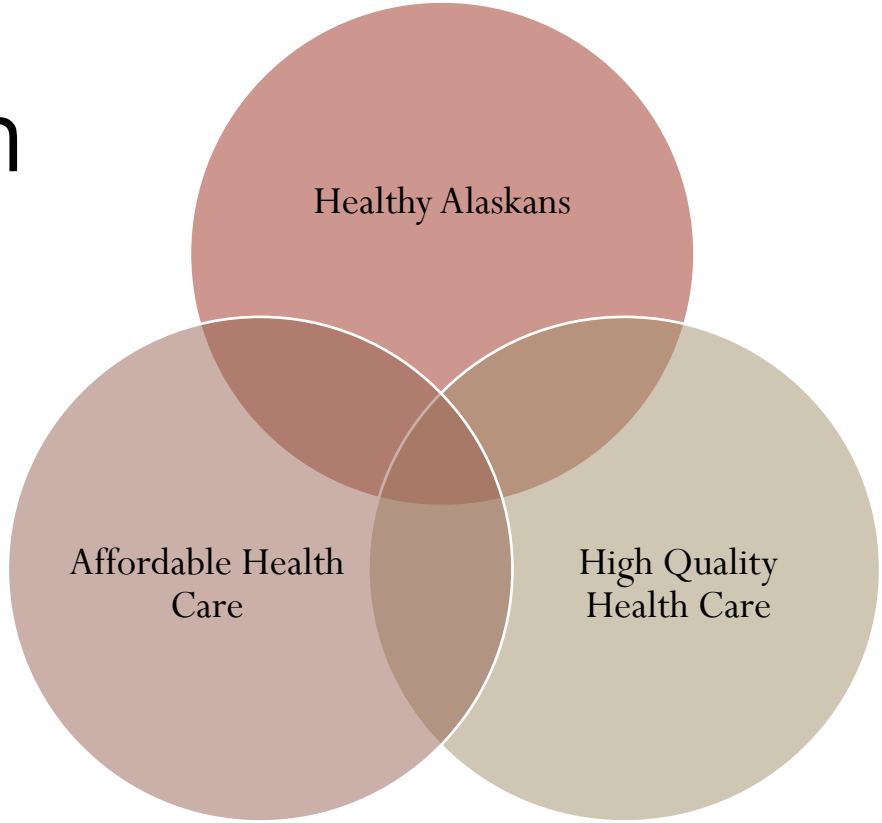
June 19 Meeting Notes in Orange

June 20 Meeting Notes in Blue

Welcome & Introductions

Commission's Vision

By 2025 Alaskans will be the healthiest people in the nation and have access to the highest quality most affordable health care.



We will know we attained this vision when, compared to the other 49 states, Alaskans have:

1. The highest life expectancy (currently 29th)
2. The highest percentage population with access to primary care (27th)
3. The lowest per capita health care spending (49th)

Recommended Strategies

I. Ensure the best available evidence is used for making decisions

II. Increase price and quality transparency

III. Pay for value

IV. Engage employers to improve health plans and employee wellness

V. Enhance quality and efficiency of care on the front-end

VI. Increase dignity and quality of care for seriously and terminally ill patients

VII. Focus on prevention

VIII. Build the foundation of a sustainable health care system

Process Reminder

- Per our By-Laws – *No Robert's Rules unless and until needed for consensus on a required decision.*

Price & Quality Transparency

2014 Strategy

Current Transparency Recommendations

1. The Alaska Health Care Commission recommends the Commissioner of the Department of Health & Social Services investigate and the Alaska Legislature support implementation of a mechanism for providing the public with information on prices for health care services offered in the state, including information on how quality and outcomes compare, so Alaskans can make informed choices as engaged consumers.

2. The Alaska Health Care Commission recommends the Commissioner of the Department of Health & Social Services mandate participation in the Hospital Discharge Database for the purpose of providing data that will lead to health care policy decisions that will improve the health of Alaskans, and to encourage federal facility participation in that database.

3. The Alaska Health Care Commission recommends the Commissioner of the Department of Health & Social Services and the Alaska Legislature immediately proceed with caution to establish an All-Payer Claims Database and take a phased approach. As part of the process:
   - Address privacy and security concerns
   - Engage stakeholders in planning and establishing parameters
   - Establish ground rules for data governance
   - Ensure appropriate analytical support to turn data into information and support appropriate use
   - Focus on consumer decision support as a first deliverable
   - Start with commercial insurer, third-party administrator, Medicaid and Medicare data collection first, then collaborate with other federal payers.

Transparency Strategy 2014

- Commission's Transparency Goal for CY 2014: Produce guidance for policy makers (and others?) for making health care price and quality more transparent.
  - 2014 Objectives (#s align with Recommendations on previous slide):
    1. Produce a paper on provider transparency:
       a) Key elements required in state legislation???

       AND/OR

       a) Principles and Guidelines
    2. Track and provide accountability for implementation of new Hospital Discharge Database (now "Alaska Health Facilities Reporting Program") Regulations.
    3. Produce a paper for legislators describing key elements required for state All-Payer Claims Database legislation.

Transparency Session Objectives

- Today's Objectives:
  I. Consider options and opportunities for additional provider transparency
     - Discuss various forms of other states' laws
     - Discuss pros and cons of such a law for Alaska, and what it might look like
     - Determine approach for moving forward – Identify key elements for state legislation, or more general Principles and Guidelines, or both?
  II. Learn status of the new Alaska Health Facilities Reporting Program (formerly Hospital Discharge Database)
  III. Work together on next draft of APCD Legislation Paper
     - Finalize this summer ***as draft*** for discussion with stakeholders and for fall stakeholder session
  IV. Plan fall Stakeholder Session on Transparency

Recent Transparency Developments

- National Update
  - Federal Government:
    - Affordable Care Act
      - Hospital Charges
        - ACA Section 2718e requires all U.S. hospitals publish how much they charge for every service.
        - CMS issued proposed regulation at the beginning of May.
        - Proposed rule states that every hospital must, at least annually, make public a list of its charges for "items and services," including charge rates for Medicare's DRGs.
        - Rule will go into effect October 1.
        - Not standardized ("how" is not dictated); charge data only.

Recent Transparency Developments

- National Update
  - Federal Government:
    - Affordable Care Act
      - Physician Payments Sunshine Act ("Open Payments Program")
        - ACA Section 6002 requires manufacturers of drugs, devices, and biologics to report payments and perks to physicians and teaching hospitals. Ownership and investments held by physicians are also reportable.
        - CMS is required to make this information public through a searchable online database.
        - Final regulation was published Feb. 8, 2013; Data collection began Aug 1, 2013
        - Public database will be online Sept 30, 2014, and will be updated annually.

Recent Transparency Developments

- National Update
  - Federal Government:
    - Affordable Care Act Provisions
      - Health Insurance Transparency
        - Uniform Summary of Coverage required
        - Transparency in Coverage Disclosures
        - Quality Reporting for Private Health Insurance

Recent Transparency Developments

- National Update
  - Federal Government:
    - CMS Medicare charge and payment data releases
      - Hospitals 2013 and 2014
      - Physicians 2014
      - Developing tools to help patients utilize data for health care choices
    - CMS quality data posted
      - HospitalCompare
      - NursingHomeCompare
      - HomeHealthCompare
    - Health Datapalooza

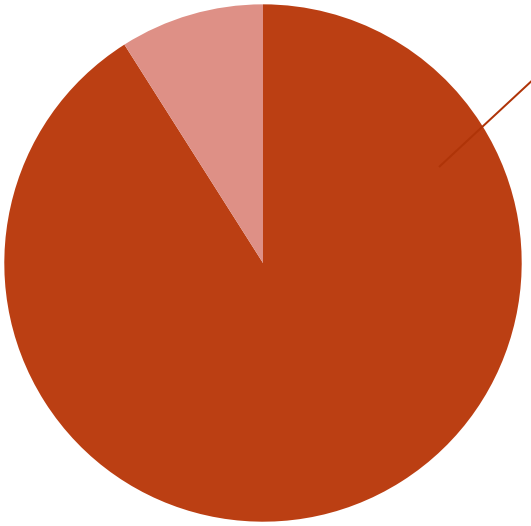
Recent Transparency Developments

- National Update
  - National organizations:
    - Health Care Financial Management Association
      - Transparency Stakeholder Task Force Principles & Guidelines Report
      - Consumer Guide to Understanding Healthcare Prices
      - Provider Price Transparency Checklist, and Patient Financial Communications best practices
    - Catalyst for Payment Reform/Healthcare Incentives Improvement Institute – Report 2013 & 2014 State Transparency Law Report Cards
    - Health Care Cost Institute – last month announced partnership with Aetna, Humana and UnitedHealthCare to compile claims data and provide a tool for the public and plan members to access data.

Recent Transparency Developments

- National Update
  - Other States:
    - 45 states have some form of transparency requirements in state law
    - 11 state have operational All-Payer Claims Databases, and 6 more are in implementation (not counting WA, CA, and WI)
      - June 17 article on APCDs in USA Today
  - Private Sector
    - Insurer and self-insured employer provided transparency tools
    - Vendors specializing in providing transparency tools, e.g., Castlight
    - Venture capitalist mobile health app development

Consumers

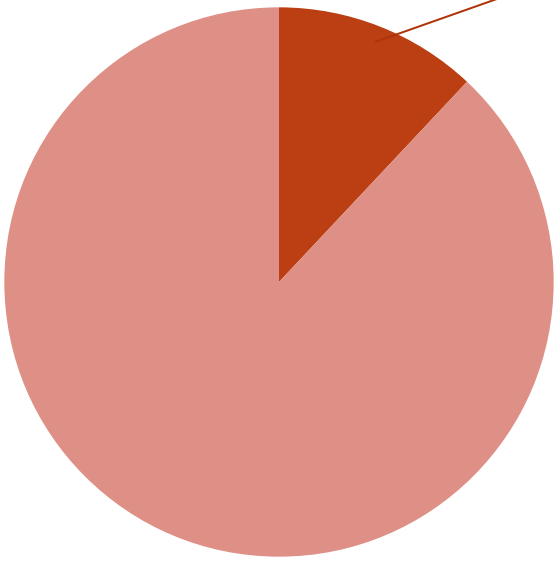


91%

of Americans feel that having information about costs before they receive care is important.

Source: Commonwealth Fund

Consumers



12%

of consumers report having used the Internet to find information on provider costs.

Consumers

- Alaskan consumer testimony to Commission

"It's very hard to be a consumer in something when you don't have a clue as to what the cost is."

"My daughter's doctor cancelled her appointment after she asked the price…"

"Secret pricing does a lot of harm."

An Alaskan testifying that he found out after the fact that he had to pay the difference between what insurance would allow and the doctor's bill, AND that he could have received the same service from four other providers within a three mile radius at a much lower price.

Transparency Law Discussion

I. Consider options and opportunities for additional provider transparency
   - Discuss various forms of other states' laws
   - Discuss pros and cons of such a law for Alaska, and what it might look like
   - Determine approach for moving forward – Identify key elements for state legislation, or more general Principles and Guidelines, or both?

- Reaction to HFMA paper
  - Comments?
  - Would this approach be Useful to inform Alaska stakeholder session?

Transparency Law Discussion

- *Reaction to HFMA paper*
  - *Comments? Would this approach be Useful to inform Alaska stakeholder session?*
  - Good to identify the roles of the various stakeholders
  - Well done – very thoughtful
  - Conclusion – we all need to get on board and do this, but how do we do this? It's really hard work.
  - The paper's a really great start, but where's the impetous
  - It's so complicated – there are so many people participating – and it can be gamed – hard to make fair to everyone involved.
  - Came away feeling as though we won't get a good product from following the recommendations
  - Gathering data from providers is complex – how do you verify they are telling the truth? Both price and quality.
  - Paper helpful and well written. Made the challenges more apparent.
  - Will take a lot of collaboration between stakeholders – what are the drivers of collaboration. Role for the Commission – Identify the drivers of collaboration.
  - Too broad for driving legislation
  - Roles defined for each stakeholders relative to different patients (by their payer source). Role for providers is for uninsured and out-of-network patients.
  - Being able to provide data to plan members is a competitive issue for insurers – being able to provide these tools is something insurance carriers compete on. Consumer tools for transparency.
  - Paper prompted questions: What's the problem we're trying to solve? What's the goal? Need clear articulation of goal. Who will be able to solve the problem? Do the potential solutions work? And will they work on our scale? Will we see a return on our investment?
  - Paper focused on price sensitivity and collaboration. Price sensitivity in Alaska isn't as important as value sensitivity.

State Price Transparency Laws

- CPR Grading Criteria for State Price Transparency Laws
  - Levels of Transparency:
    - Prices reported to the State only
    - Prices available upon request by individual consumer
    - Prices available in a public report
    - Prices available via a public website
  - Scope of Transparency:
    - Scope of Price: charges, average charges, amount paid by insurer, amount paid by consumer
    - Scope of Service: all medical, inpatient, outpatient, most common inpatient and outpatient
    - Scope of Providers: hospitals, physicians, surgical centers

State Transparency Law Examples

- Require insurance carriers to release claims data to employers/group policy holders
- Prohibit gag clauses in health plan/provider agreements that create barriers to release of quality and price information
- Require providers to reveal price when asked
- Require providers to provide price data to State government
- Require providers to post prices on-line for top procedures by utilization and/or revenue
- Require providers and/or insurance carriers to submit financial performance data to State government
- Require State agency to produce reports for the public
  - Health care organization financial performance
  - Provider prices, public payer fee schedules, etc.

Transparency (notes from flip charts)

- Quality must be included
- Are patient incentives aligned?
- It's complicated
- Health plan member education is important
- Provider staff education is important
- We can be selective, e.g., start with elective procedures
- Need to foster patient/consumer engagement
  - Price sensitivity
    - High Deductible Health Plans – marketplace is starting to drive this – ACA
- Patient relationship with provider is important
- Local health care market and choice is important
- Decreased utilization 30% when HDHP coupled with transparency with no change in health status
  - Concern re: prevention, but new plans provide first $ coverage for preventive services
- Price Sensitivity – Concierge Services?

Transparency Law Discussion

- Legislative Considerations – balancing:
  - Consumer protection – right of patient and referring physician to know the cost
  - How do you dove-tail that with industry concerns and preferred approach?
- What is our goal – what is the problem we're trying to solve?
- Use HFMA Task Force Report as a starting point, and start with developing Principles & Guidelines

Hospital Discharge Data Next Steps

II. Learn status of the new Alaska Health Facilities Reporting Program (formerly Hospital Discharge Database)

- First public comment last fall
- Draft regs revised in response to comments
  - Added most Certificate of Need covered health care facilities
- 2nd draft released March
- Public comment closed; Final regs in legal review
- First provider meeting was held Tuesday; second will be held next Wednesday

APCD Next Steps

III. Work together on next draft of APCD Legislation Paper

- Finalize this summer ***as draft*** for discussion with stakeholders and for fall stakeholder session

Stakeholder Session

IV. Plan fall Stakeholder Session on Transparency

- Questions for planning stakeholder session
  - Who to invite?
  - How should we solicit patient/consumer input?
  - Process recommendations?
  - Pre-meeting prep recommendations?

2014 Legislative Session

See handout

Insurance Rules & Market Function

Insurance Market Regulation

- Commission Findings generating a lot of interest and discussion:
  - **Market forces affecting pricing for health care services are impacted by state laws and regulations in Alaska.** There are state laws and regulations in place that influence the market in such a way as to drive prices higher for the consumer. (Milliman)
    - Lower physician discounts in Alaska can be at least partly explained by the relative lack of competition among providers, particularly for specialty care. In many areas, including Anchorage, there are a limited number of providers in any given specialty (sometimes only one provider group). As a result, physicians can largely dictate the fees they are paid by commercial payers.
    - Relative provider leverage may be further exacerbated by Alaska's regulation requiring usual and customary charge payment to be at least equal to the 80th percentile of charges by geographic area. Since many providers have over 20% of their market share, this implies that those providers can ensure that their charges are below the 80th percentile and therefore, receive payment for their full billed charges. (3 AAC 26.110)
    - A separate state law requires payers to reimburse non-contracted providers directly instead of through the patient, removing incentives typically used by payers to encourage providers to join their networks. (AS 21.54.020)

Insurance Market Regulation

- Plus --- New, Additional, Related Issues
  - Changes to Alaska HMO law?
    - Air Ambulance Insurance legislation just passed
    - "Concierge Medicine" questions to Division of Insurance
      - Retainer agreements
      - "Boutique" practice

Insurance Market Regulation

1. Should the Commission develop recommendations regarding findings/other insurance market regulation?

2. What are some of the policy considerations in deciding "whether" and "what" insurance market regulatory/statutory changes to make?

Employer Health Benefit Survey

Survey Results Presented by ISER

See handout

Take-Aways? Important points learned from Survey Results?

- Alaskans think wellness is important, but too busy to do it ourselves.
- Employers 1-9 FTE is where the largest gap in ESI coverage is – what do we do with that?
- Important to think of the senior population as an economic force
- Stunned by the gap in what AKn employers are doing related to wellness and the national numbers….what is the reason why that gap is so large?
- Baby boomers in the workforce now – how will that change the workforce demographic over time? How will that impact the ESI coverage picture over time?

Unanswered questions – Additional info needed?

- Seniors:
  - population demographic and geographic trends, including migration, including seasonal migration?
  - Senior needs?
  - Senior impact on economy?
- Seasonality of economy and workforce and population…
- Age composition of workers?
- Confusion re: HRA IRS rules – can a policy change be made at the federal level to better engage small employers
- Understanding at a deeper level Benefit design is essential to understanding how ESI and employers are impacting the health care market

Unanswered questions – Additional info needed?

- What are TRICARE, Medicare and Tribal health system and Medicaid doing re: Wellness? How do they incentivize wellness?

- Wellness question in survey was pretty broad…there is a cost to wellness…there are targeted interventions that do make a difference (tobacco cessation), others in the "feel good" category, others that don't turn an ROI but are "the right thing to do". Need economists' expertise on ROI of wellness. Check with HealthAtWork/Andrew Sykes – wellness actuarial analysis.
- Disease management vs. Wellness vs. complex case management?

- What is the impact of HDHPs on employee engagement?
- What is the impact of the ACA's $2400 limit?
- What's the tipping point for "underinsurance"? Where deductibles are so high it impacts access to care?
- REPEAT STUDY in 2 or 3 YEARS to track how employer practices and prices are changing

Unanswered questions – for Alaskan employers?

- Are you moving away from more traditional, comprehensive plans to HDHPs and other new plan designs?
- Are you offering medical care directly to your employees? Are there other alternative ways you are looking at providing medical care for employees.
- How are health care costs affecting business decisions?
  - Of private sector employers?
  - Of public sector employers? State, Local/School District, Military

Insurance Coverage

What Questions do we have About Insurance Coverage in Alaska?

- Are AI/AN considered uninsured? What is the difference between insurance coverage and other forms of health benefits. Indian Health Service benefits do not guarantee access to service – there is not a defined benefits package through the IHS, as there is under an insurance plan.
- Should we define insurance coverage?
- How do insurance plans in Alaska compare to insurance plans in other states? How do benefit design, deductible and co-pay provisions compare?
- Is insurance as we know it today ever going to be able to meet the needs of the uninsured?

What Questions do we have About Insurance Coverage in Alaska?

- Of the benefits of insurance, to what extent do the lower negotiated rates factor in?
- To what extent and how can insurance companies control hospital and physician prices in Alaska?
- Eligibility for insurance is one question – affordability of insurance is another question.
- The underlying question is economic access to health care.
- ***How does insurance status affect access to health care?***

Insurance Coverage Questions (notes from flip chart)

- Sources of coverage?
- Reasons for not enrolling in ESI (Employer-Sponsored Insurance)?
- Demographics of insured and uninsured populations?
  - Especially age
- What is the effectiveness of wellness programs?
- How do we define:
  - Access?
  - Equity?

Day 2: June 20

Recap Discussion

Take-Aways from Yesterday's Sessions

Take-Aways from Yesterday

- Transparency will help the price/cost problem, but we have to be very careful. Can we have a good law that will cover all the needs. But we've got to get started on it – need to have a good quality measure(s) to go along with the price data. Balance simplicity with needed data.
- Uninsured become a large portion of the uncollectibles – can we expand ESI for small employers so bad debt doesn't build up for providers. Need affordable product for small employers.
- Employer survey results very helpful. There seems to be a better appreciation for the policy issues/questions.
- APCD would be a good thing, but we don't see dramatic success yet from doing that (from other states). Healthcare Cost Institute example – Payers/insurers are starting to come together to share data in a non-governmental way.
- Appreciated Becky's perspective as a new member – we need to clarify our goal as it pertains to transparency. There's a big human element and consumer responsibility. How do we educate and encourage consumers to do that? A lot of factors to consider. Interesting to hear about the gaming aspect – how will it influence our opportunities for success?
- Do we need a limited scope database on limited procedures? Elective procedures. How do you capture quality so it's comparable and fair? How do we use APCD to answer the quality question? What are the effects of health care "crowd-out" on the overall economy? The only question that matters, is – are the funds being used efficiently?

Take-Aways from Yesterday

- Quality parameters – some orthopedists (as an example) take on the toughest cases and some take on the "healthy" cases – simple quality parameters may skew the data. HDHP – uninsurance vs. underinsurance; but will add price sensitivity (already has). If we can get to a workable number for the top 30 surgical cases – need to get to comparable definition of cases. Quality is already on internet (good or not). Only thing folks don't have is price – we need to get to that.
- Price information available to all is important. Getting through the legislative process is a challenge because they'll be hearing from industry, not from citizens. Commission can help educate the legislature on how the market works. Collaboration is important, between insurers, between providers – battles between different segments of industry in legislative process. If things get tight who's going to lose (on economic impact question)?
- Collaboration between stakeholders is important – it's critical – won't work without it. Not concerned with things that will encourage collaboration – the ACA is already impacting and shifting the market – there will be collaboration driven as a result. Concern that law may be a bad law – no law better than bad law. Collaboration – collective wisdom better than individual. Phased approach better than major change. Can we do it (APCD) a bite at a time? E.g., most common procedures…

Take-Aways from Yesterday

- 2 issues driving Fairbanks economy wild right now are health care costs (particularly elder care and mental health) and energy. In Fairbanks we have a lot of military retirees who bring their retirement dollars to the community and take lower wage jobs. If the cost burden gets too great they take their retirement dollars to another community (they prefer to stay for quality of life, but leave when costs get too high). When it comes to the price sensitivity question we're at a stress point because choice is so limited in smaller, more remote community. APCD – it was well said that industry more interested than consumers, until consumers feel they really need to know – but it's a "value" issue, not a "price" issue. Trust factor is important. APCD is as important to doctor as it is to consumer. How do we get to transparency system/mechanism that really helps patients see up front what to expect? Does an APCD help the doctor and patient get there? Elective procedures/non-emergent major procedures, is where price sensitivity is working the most for now. How do we draw doctors into this discussion? Will the APCD help this? Will it help doctors?
- In general – there's a growing interest and concern about costs – people are starting to feel the pain and even if use of APCD by patients would be low at first it could grow over time.

Take-Aways from Yesterday

- If we don't turn the curve on healthcare cost growth we'll be at 100% of gdp some day. And there's a lot (30%) waste. One form of waste is price and efficiency – price that's extraordinarily high relative to market. Example of higher quality at much lower price of family member procedure. But referring physicians don't know. But it's really really complicated. Insurers have armies of actuaries who have been working this out. So insurers/private sector is making lots of progress on consumer transparency tools. It is impossible for us (Commission) to do this (figure out the details of how to do this). We can lay out the principles. What if we ask Premera and Aetna to make their tools available to the uninsured? – for the public who don't have access to transparency tools.

Fraud & Abuse Prevention

Presentation by Gordon Grundy, MD

Medical Director, Special Investigations Unit, Aetna

Group Discussion with:

Douglas Jones

Medicaid Program Integrity Manager, Alaska Department of Health & Social Services

Andrew Peterson

Assistant Attorney General, Director, Medicaid Fraud Control Unit, Alaska Department of Law

Margaret Brodie

Director, Division of Health Care Services, Alaska Department of Health & Social Services

Lydia Bartholomew, MD, MHA, FACPE

Senior Medical Director, West Region Patient Management, Aetna

Fraud & Abuse

- **Draft Findings From March 2014 Commission Meeting**
  - CMS/Medicaid estimates 3-10% of spending is fraud; we're recovering here in Alaska <1% - our programs are doing a great job; but,
    - Realigning fee structures, creating a more even negotiating field, and evidence-based practice and coverage is what is going to make the difference in addressing our cost challenges (Nationally $1T in health care "waste" vs. $30B lost to fraud)
  - But 1% recovery doesn't include savings from deterrence
  - New MMIS will help (once it's working)…New provider enrollment system should improve ability to streamline/manage/facilitate audit process (will add power to identifying fraud, and hopefully will relieve providers generally)

Fraud & Abuse

- **Draft Findings From March 2014 Commission Meeting**
  - Current Medicaid Fraud Control program has a backlog — what can be done to help alleviate that?
  - If they had more people/staff in the programs they could do more
  - How do private sector payers control fraud and abuse?
  - Medicaid is operating under federal controls – is there an opportunity for state law/reg/program improvement?
  - In behavioral health world – the process of billing for behavioral health is questionable – Two issues: Transparency, and clarity of the process
    - Current fraud programs aren't prosecuting much in the behavioral health sector because of lack of clarity regarding diagnosis and payment standards – is there something we can do to help in this area?
    - Could the Commissioner and the Alaska Mental Health Trust Authority explain to the commission how grant financing and Medicaid financing of behavioral health services work and inter-relate? Eligibility and categories of eligibility? We need DHSS to explain how they categorize and conduct grant reviews and how does fraud investigation work currently?

Fraud & Abuse

- **Draft Recommendations From March 2014 Commission Meeting**
  - # of audits providers are subject to seem daunting – is there something we can do/recommend to streamline the audits/audit processes to lessen the burden on providers (which is currently compounded by the Medicaid Management Information System transition)?
  - Could/should provider enrollment be streamlined?
  - What could help to alleviate the Medicaid fraud investigations back-log? Additional staff?
  - Are there opportunities for improvement in and streamlining between federal and state laws and programs for Medicaid fraud control?
  - Could we help in the behavioral health arena with fraud – better diagnosis and payment standards?

Medicaid Fraud Control Improvement Ideas

- Enrollment of rendering providers
- "Meyers & Staufer Audits" (AS 7.05.200)… eliminate/repurpose some or all discretionary audits and target provider types that pose greatest risk of overpayment
- Reduce cycle time from audit notification through final report issuance
  - More proactive communication with providers
  - On-line dashboard – status of audit/investigation
- Strengthen collaboration
- MFCU Since Oct 2012: 93 criminal cases; 62 convictions; provided program integrity with info to suspend 7 agencies

Medicaid Fraud Control Improvement Ideas

- One large case investigating 53 individuals, 35 convictions, $743,000 saved – bringing total to $12,000,000 for SOA
- OIG moved staff out of Alaska back when Dept of Law and DHSS weren't collaborating because there wasn't enough work. Two departments actively collaborating now. And now as soon as search warrant issued by MFCU, MIP provided data to suspend providers before criminal investigation is complete so $ path is cut off and not throwing good $ after bad. Judicious about using suspension process.
- Dept of Law has been hiring investigators with law enforcement experience (but then lack health care experience), so relying on DHSS staff to help with audits. DSDS/DHSS quality assurance staff working very closely with Dept. of Law/MFCU
- MFCU working with OIG very closely (they're looking at reestablishing an office up here); US Atty from ND is going to start working part time in/for/on Alaska cases.
- MFCU reaching out to other agencies to increase collaboration

Medicaid fraud control improvement ideas

- Side benefit – judges are starting to recognize/understand health care fraud better
- Fraudulent providers are exploiting vulnerabilities in the system. Recipients have no "skin in the game", and also don't receive an EOB (so can't see if a provider is billing for services on their behalf that they did not receive). Lack of enrollment of some provider types doesn't allow for identifying fraudulent providers caught in one area (where they are enrolled) who continue to bill in other areas where not enrolled.
- Increased administrative filings
- M&S audits don't generally identify criminal activity, but one recently identified fraud case will result in $1M savings/year for SOA --- they are turning a benefit.
- One concept to look at legislatively – how do we capture the money that is gone (e.g., bonding, strengthen state seizure law)?

Medicaid fraud control improvement ideas

- Who is auditing hospital charges? If DRGs aren't being audited are they auditing fee-for-service charges only?
  - Medicaid rate review uses facility Medicare cost report to set a per diem rate based on the audit conducted in rate-setting process
  - M&S audits just look for other third party payment, overpayment of approved rate, and proof that patient was in the hospital for the dates charged. Utilization review contractor looks at medical necessity.
- For in-patient services, PA and utilization review, not fraud audits, are going to catch the problems in Alaska (small state/few hospitals make fraud harder to do)
- OIG has provided lots of technical support; Immigration has helped provide information on out-of-country travel of providers billing for Alaska services
- Bond and forfeiture law good ideas for state law change. How can provider enrollment be increased?…regulatory change.
- RAC process presumes guilt; waivers***

Medicaid Claims Management

- Medicaid Claims Management Tools
  - Prior authorization for medical necessity
  - Pre-payment review for providers who have billed for services inappropriately (can't prove fraud, so provide education and 1 on 1 intervention)
  - SURS – Service Utilization Reviews – looking for providers who are outliers from everyone else. E.g., tobacco cessation – is a provider billing for every single person they see? For 2 year olds? Outliers are put in queue to be investigated. It's a big burden to providers because they are asked to provide entire patient history, so DHCS is streamlining process and target outlying procedure to lessen burden and shorten time it takes
  - OverUtilizers of EDs in Anchorage and MatSu. Beneficiaries are getting a letter being mailed today to ask for volunteers. May be targeting close to 5,000 beneficiaries. 4 providers responded to RFP. Be on the lookout in September for national article going out on data analytics we used.
  - Bens found to be travelling without attending medical appointment will be getting letters requesting state money back (and also will be looking at people arranging/approving travel for fraud on their behalf)
  - Cash for prescriptions?
  - Electronic verification of PCA services – RFP going out – pilot – PCA will have to check in and out of homes electronically, and that data will be matched against Medicaid claims
  - More info on providers; enrollment of rendering of providers

Medicaid Fraud Improvement

- Barriers
  - Prescription Drug Database
    - Statutory barrier currently prohibits Medicaid managers from accessing prescription drug database; and Dept of Law without a warrant
    - Real-time would allow rapid identification, but what we have now at least allows for patterns,
    - Would make a big difference for Alaska to provide state support and continue the database; real-time support would be an even better tool.
  - Enrolling new provider types not currently enrolled will have a workload impact – DHSS will need the resources to manage it

Preliminary Fraud Recommendations

- Seek waiver of Medicaid RAC requirement?
- Statutory Changes needed
  - Ability to require bonding, and forfeiture
  - Are there statutory barriers to collaboration between Dept of Law and providers? To working proactively for education?
- RAC auditor leaving a good thing – seek a waiver from the federal government to continuing that program in Alaska
- Prescription drug program – need to expand to a more robust program in Alaska (such as Washington's); and need to change legislation to allow Medicaid program and Dept of Law to access the data
- Medicaid needs to enroll rendering providers
- Home care/community-based provider workforce is a large and growing workforce; important needs, but great risk sending folks out into homes of vulnerable individual unsupervised. What's the role of technology in helping check background and also strengthen documentation of services provided. Need more checks and balances.

Good Bye & Thanks to Jeff

Jeff's Parting Thoughts

- Structural problems in Alaska's insurance market (private insurance market sets the bar for other payers):
  - 80th percentile regulation designed to protect consumers, but market has grown up since then. One option – exempt carriers with sufficient networks (network adequacy standard)
  - Assignment of benefit law takes away carrier negotiating tool/lever
  - Anti-HMO language sprinkled through-out AK insurance law interfere with payment reform to align incentives of providers, payers and patients.
- Ideal health care system – eliminate waste and improve quality
  - Physician driven, physician governed
  - Centered around primary care
  - PC docs would be given the resources they need – money to do the extra work plus information needed to do the work - to reengineer the care at the site of care
  - Alaskans would take personal responsibility for their health (75% of costs due to chronic conditions)

Affordable Care Act & Medicaid Reform Advisory Group Update

Discussion with Commissioner Streur

ACA Update: Insurance Market & HIX

- Alaska
  - Federal Exchange
    - 2015 Rate Filings for Federal Exchange participation in Alaska are due to the Division of Insurance June 30.
    - Rate filing approvals are due from the Alaska Division of Insurance to the federal government July 31.
    - Division of Insurance is not allowed to release the rates until January 1, 2015, but carriers and/or the federal government may.
    - SHOP: Alaska Employee Choice Waiver approved by feds for 2015 (AK one of 18 States)
  - Federal rule changes are keeping Alaska Division of Insurance staff hopping

- 10 other states have released their 2015 HIX rate filings, of those 0 carriers are dropping out, and a total 27 new carriers are entering the markets. Rates (not yet approved) in some cases are increasing by double-digits, and some are going down.

ACA Update – Medicaid

- State Medicaid expansion decisions, as of June 10, 2014:
  - 26 States (+ WA DC) implementing expansion in 2014
    - Arkansas, Iowa and Michigan have approved waivers for alternative expansion plans
    - New Hampshire plans to seek a waiver
  - 21 States *(including Alaska)* do not plan to expand at this time
    - CMS issued guidance to States in December 2012 clarifying that there is no deadline by which a State must make a decision regarding Medicaid expansion.
    - WI amended an existing waiver to cover adults up to 100% FPL, but did not adopt expansion.
  - 3 States in open debate: Indiana, Pennsylvania, Utah
    - Indiana and Pennsylvania have pending waivers for alternative Medicaid expansion plans.

Next Steps: Transparency

- Don't plan a stakeholder session for the fall at this point
- Potential Learning Session for 2015
  - What are insurers doing to support transparency for plan members?
  - What are employers doing to support transparency for employees?
  - What private sector vendor tools for transparency are being developed and adopted?
  - What are the other states' transparency laws and how are they working?

Next Steps: Ideas for Fall Clinical Quality Improvement Learning Session

- Look at hospital/health system quality improvement initiatives, and how they connect to clinics:
  - Virginia Mason & Toyota Lean
  - Institute for Healthcare Improvement
  - Southcentral Foundation – Dr. Tierney
- Quality is good, but what works to improve outcomes, reduce costs and eliminate waste?

Wrap-up: Meeting Evaluation (from flip chart pages)

- Liked about this meeting:
  - Session on fraud and abuse was interesting – good ideas for improvement presented
  - Discussions were substantive
  - Alaskan employer survey results were very interesting
  - Jeff Davis' parting thoughts on how to improve health care in Alaska now, and what the idea future health care system for Alaska looks like, were good.
  - Lunch
- Wishes for future meetings:
  - Ice cream
  - Alaska-focused presentations
  - More focused questions and direction in facilitation
  - 2-day meetings are too long – go back to 1.5 day meetings

2014 Meeting Schedule

- Friday, March 21 – Saturday, March 22
- Thursday, June 19 – Friday, June 20
- Thursday, August 14 – Friday, August 15
- *Wednesday, October 1: Transparency Stakeholder Session? Health Historians Session?*
- Thursday, October 2 – Friday, October 3
- *November: Public Comment on Draft Findings & Recommendations*
- Tuesday, December 9: *One day meeting to finalize 2014 Findings & Recommendations*